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Review Article

**FACTORS CONTRIBUTING TO ANXIETY DISORDER
AMONG SOCIETY**

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Abstract:

Anxiety disorders are very common and can present with a variety of signs and symptoms. We have reviewed the literature through most known databases for published medical papers; MedLine and PubMed for relevant articles that were published in English up to beginning of 2021. The condition has a high morbidity and mortality rate and is best managed by an inter-professional team consisting of a mental health nurse, pharmacist, psychologist, psychiatrist, and primary care provider. Many patients suffer from moderate to severe symptoms, resulting in a low quality of life. Most people are unaware that the condition can be treated. As a result, patient education is critical to improving outcomes.

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INTRODUCTION:

Social anxiety disorder (SAD) is a condition that starts in childhood/adolescence and When confronted with social exposure situations in public or meeting new people, the individual experiences excessive fear or intense anxiety. It is estimated that between 5% and 13% of the population suffers from this condition. It is regarded as a chronic pathology capable of incapacitating the individual and promoting the development of high rates of psychiatric comorbidities, including depression, generalized anxiety disorder, and agoraphobia, the most common anxiety disorder and the third most common psychiatric disorder [1,2]. Fear, worry, and a constant sense of being overwhelmed characterize generalized anxiety disorder (GAD). The symptoms of generalized anxiety disorder are persistent, excessive, and unrealistic worry about everyday things. This worry could be multifocal such as finance, family, health, and the future. It is excessive, difficult to control, and is often accompanied by many non-specific psychological and physical symptoms [2,3,4].

Childhood anxiety affects approximately one in every four children between the ages of 13 and 18 years. The average age of onset is 11 years. In children aged 13 to 18, the lifetime prevalence of a severe anxiety disorder is approximately 6%. The overall prevalence in children under the age of 18 ranges between 5.7% and 12.8%. The prevalence is roughly twice as high in women as in men [3,4,5,6].

The initial evaluation begins with addressing behavioral or somatic symptoms. Psychosocial stress, psychosocial difficulties, and developmental issues should all be considered. Examine your medical history, paying special attention to trauma, psychiatric conditions, and substance abuse. [7].

METHODOLOGY:

A Narrative review of the literature was carried out based on a search in the Medical Literature Analyses and Retrieval Online (Medline), Latin American and Caribbean Literature in Health Sciences (LILACS), PubMed, and the Cochrane Library databases. For each research portal, a specific strategy was developed for crossing Descriptors in Health Sciences. The selection was limited to studies published in English, up to February, 2021.

DISCUSSION:

Depression and anxiety lead to a serious impairment of daily functioning and quality of life. In frail elderly, the effects of depression and anxiety are especially deep encroaching. Besides a deleterious effect on daily

functioning and quality of life, a large number of studies demonstrate excess mortality, disability, handicap and service utilisation [8]. The elderly population is rapidly increasing. Almost a third of elderly subjects in the community with subthreshold depression or anxiety will develop a major depressive or anxiety disorder in three years [9]. Therefore, preventing the onset or development of these disorders has a high priority [10]. There are three types of prevention: universal prevention, selective prevention, and indicated prevention. The goals of these types of preventive interventions are to reduce the occurrence of new cases and to postpone the onset of illness. Furthermore, the goals of the suggested preventive interventions may be to shorten the duration of the persistence of early symptoms and to halt the progression of severity so that the subject does not meet DSM IV diagnostic levels [11]. Indicated prevention studies have demonstrated that well-designed interventions can reduce the prevalence of depression and anxiety [12]. Furthermore, they are likely to be less expensive than alternative approaches [13]. So, favorable prevention should be well designed and should be aimed at selected groups of elderly, at high risk of developing anxiety or depression. Selected risk factors for the onset of late life depression are [14]: loss of a partner, chronic illness, neuroticism, family history, lack of social support and subthreshold anxiety or depression disorders.

In accord with previous research, a single factor described the latent structure of five anxiety disorders well, supporting the existence of a latent shared risk for these disorders. Previous studies have shown that part of this shared risk is due to shared genetic and environmental liability [10,13,14]. And one previous study extends these prior findings by identifying some of the risk factors that may underlie those shared liabilities [12]. The risk factors examined in this study were based on a conceptual model for risk of anxiety, and had previously shown promising results in also predicting the risk of GAD [15]. However, one previous study suggests that the model may have broader applicability than previously thought and may help understand the etiology of a wider range of internalizing disorders and their high rates of co-occurrence. Furthermore, the finding that the disorders differed in their loadings on the latent factor indicates that the disorders have shared but also specific risk factors. In particular, anxiety disorder had the lowest loading, suggesting that anxiety may stand a bit apart from the anxiety disorders, as previously suggested [12].

In accord with previous studies, [15,16], when examined separately in the bivariate analyses, most risk factors increased the odds of all the anxiety disorders, suggesting that they might be common risk factors for these disorders. Consistent with this view, the results of the multiple indicators multiple causes (MIMIC) approach model indicated that most of the effects of the risk factors were exerted through the latent variable representing the shared liability for all the disorders. In fact, in some cases, such as childhood sexual abuse, the effect was exclusively through the latent variable, in line with prior findings on the effect of child maltreatment on the structure of psychiatric disorders [17]. For example, through its effect on the latent factor, a history of childhood sexual abuse increased by 0.24 standard deviations the risk of having history of substance use disorder (SUD), GAD, or specific phobia, by 0.22 standard deviations the risk of having panic disorder, 0.18 standard deviations the risk of PTSD, and 0.17 standard deviations the risk of social anxiety. There is a need to better understand the psychological and biological mechanisms underlying the generalized effects of these risk factors [18,19,20].

At the same time, as could be expected from the different magnitudes of the association between the risk factors and the different disorders observed in the bivariate analyses, not all the effects of the risk factors occurred through the latent variable. Nineteen of the possible 66 disorder-specific effects were significant, and for each disorder, there was at least one significant direct effect. Our results indicate that, in addition to the shared etiology that pulls them together, all anxiety disorders have specific effects of risk factors that contribute to their individuality. For example, family history of anxiety had a substantial specific effect on anxiety in addition to its effect on the latent variable, indicating that this risk factor may contribute to the risk of anxiety beyond the risk it confers to anxiety disorders. Similarly, we found that low self-esteem, which has been previously documented among individuals with SAD but also associated with a broad range of mental disorders, has a stronger association with SAD than with other anxiety disorders. The anxiety about one's performance and fear of negative evaluation by others may lead individuals to internalize some of those perceptions leading to low self-esteem. Alternatively, low self-esteem might make individuals more reliant on the opinions of others, which may lead to anxiety about their evaluation [21,22,23].

Traumatic experiences had a large specific effect on PTSD above and beyond their effect on the latent factor, whereas being White constituted a specific

protective factor (i.e., after adjusting for the effect of race on the latent factor), probably as a result of lower exposure to trauma of White individuals [24]. A surprising finding was that history of SUD before age 21 decreased the risk of PTSD. It is possible that substance use may mask or decrease the intensity of some anxiety symptoms. Alternatively, early-onset SUD may indicate a greater propensity for externalizing disorders than for some internalizing disorders. Despite these isolated findings, overall, the specific effects that were significant in our analyses are consistent with specific risk factors identified in previous studies, and are informative about how risk factors may shape individual disorders by involving mechanisms that may be less salient for other disorders [25,26].

CONCLUSION:

Anxiety disorder risk appears to be mediated in part by a latent variable that underpins various illnesses and in part by disease-specific effects. The shared risk may contribute to the high rates of disorder comorbidity, aid in the identification of commonality in the etiologies of different illnesses, and provide hints for the development of unified treatment regimens or integrated preventative initiatives. Disorder-specific impacts may contribute to the various characteristics of each disorder's etiology and imply the need for management flexibility. These findings may serve to inform dimensional models of psychiatric condition classification.

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